COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2012-209

VICKIE LARABEE — APPELLANT

VS.

FINAL ORDER
SUSTAINING HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

CABINET FOR HEALTH AND FAMILY SERVICES
J.P. HAMM, APPOINTING AUTHORITY — APPELLEE

** ** ** ** **

The Board at its regular September 2013 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated July 23, 2013, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be, and they hereby are approved, adopted and incorporated herein by reference as a part of this Order, and the Appellant's appeal is therefore **DISMISSED.**

The parties shall take notice that this Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

SO ORDERED this 17th day of September, 2013.

KENTUCKY PERSONNEL BOARD

MARK A. SIPEK, SECRETARY

A copy hereof this day sent to:

Hon. Carrie Cotton
Vickie Larabee
J.P. Hamm

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2012-209

VICKIE LARABEE **APPELLANT**

VS. **FINDINGS OF FACT, CONCLUSION OF LAW AND RECOMMENDED ORDER**

CABINET FOR HEALTH AND FAMILY SERVICES
J. P. HAMM, APPOINTING AUTHORITY **APPELLEE**

** ** ** ** **

This matter came on for evidentiary hearing on June 5, 2013, at 9:30 a.m., at 28 Fountain Place, Frankfort, Kentucky, before Geoffrey B. Greenawalt, Hearing Officer. The proceedings were recorded by audio/video equipment and were authorized by virtue of KRS Chapter 18A.

The Appellant, Vickie Larabee, was present at the evidentiary hearing and was not represented by legal counsel. The Appellee, Cabinet for Health and Family Services, was present and was represented by the Hon. Michael Board.

The issue at the evidentiary hearing was the Appellant's five-day suspension without pay. The burden of proof was upon the Appellee to demonstrate by a preponderance of the evidence that the disciplinary action taken against Appellant was neither excessive nor erroneous and was taken with just cause.

BACKGROUND

1. The Appellant, Vickie Larabee, timely filed her appeal with the Personnel Board on September 14, 2012, appealing from her five-day suspension from duty and pay from her position as a Nurse Aide State Registered I, with the Department for Behavioral Health, Developmental and Intellectual Disabilities, Glasgow State Nursing Facility (GSNF).

2. The first to testify was **Ms. Melissa Copas**, also known as Lisa Copas. Ms. Copas testified that she has been employed at the GSNF for twelve years, with the last three years being in the position of Risk Manager. Her duties as Risk Manager included investigating client related incidents at the subject facility.

3. Appellee's Exhibit 1 was introduced into the record through the witness and is a copy of Ms. Copas' Final Investigative Report dated June 18, 2012. The report was placed under seal. Ms. Copas testified that she was instructed to investigate an incident regarding Client #1 which occurred at the GSNF on June 12, 2012. In essence, while under the care and supervision

of the Appellant, Client #1 got up from the breakfast table, wandered out of the dining room and fell. Client #1 sustained minor injuries as a result of the fall.

4. Ms. Copas interviewed the client and staff who were on the floor at the time of the incident. She also reviewed the client's care plans, the nurses' notes, etc. Page 4 of the report lists the attachments reviewed. Ms. Copas concluded that no abuse or neglect could be substantiated, but there were performance issues regarding a failure to adhere to Client #1's care plan. [See attachment 21 on p. 6 of 11 to the Final Investigative Report.]

5. The next to testify was **Ms. Emily Blythe**, who is a Medication Aide at the GSNF. Ms. Blythe's job duties included giving the clients their medications and assisting them with their everyday care, such as feeding, bathing, etc. Ms. Blythe has been in this position for approximately five years.

6. On June 12, 2012, Ms. Blythe was working the first shift between 7:00 a.m. and 3:00 p.m. As a Nurse Aide, one of her duties was to walk the clients to the dining room for their meals. Ms. Blythe explained that at the GSNF there are two dining rooms. One was referred to as the "central" dining room where clients in need of no special attention were taken to eat. The other was referred to as the "restorative" dining room where clients in need of assistance with their meals were taken to eat. Ms. Blythe stated that there are typically two aides in each dining room during mealtime.

7. Ms. Blythe explained that on the morning of June 12, 2012, she took Client #1 to the restorative dining room. When she left Client #1, he was just sitting there and seemed fine. Ms. Blythe further explained that there are typically between 10 – 12 clients in the restorative dining room and 15 – 20 in the central dining room at one time.

8. The next to testify was **Ms. Heather Hagan**, who works as a Nurse Aide at the GSNF. Ms. Hagan explained that her job duties included assisting the clients in their daily activities. She has been in the same position for approximately four years.

9. On June 12, 2012, Ms. Hagan, along with the Appellant, was working the first shift between 7 a.m. and 3 p.m., and was in the restorative dining room assisting clients with their morning meal. Ms. Hagan was aware Client #1 was in the dining room and knew of his care plan. She also knew Client #1 was to be monitored for any wandering activities and needed assistance ambulating.

10. Finally, Ms. Hagan testified that on the morning of June 12, 2012, Client #1 got up and wandered out of the restorative dining room without her or the Appellant noticing and ended up falling down and hurting himself. Ms. Hagan received a five-day suspension from duty and pay as a result of her failure to properly monitor Client #1 and did not appeal her suspension.

11. The next to testify was **Ms. Hilary Garrett**, who is an LPN at the GSNF. She has been at the subject facility for nineteen years; thirteen as a LPN and six as a Nurse Aide. Ms. Garrett explained that she was working the first shift on the morning of June 12, 2012 between the hours of 7 a.m. and 3 p.m.

12. Ms. Garrett testified that she was near the central dining room setting up her medical cart when she heard a thud. It turned out it was Client #1 who had fallen. When she turned around she saw Client #1 laying on his right side approximately six feet away. Ms. Garrett called for Anthony London for assistance. According to Ms. Garrett, Client #1 was approximately eight feet away from the restorative dining room when he fell which resulted in an abrasion to his right forehead. Client #1 was eventually sent to the hospital for stitches.

13. The next to testify was **Mr. Anthony London**, who is employed at the GSNF as an RN. Mr. London has worked as an RN at the facility since 2005. He explained that he was working the morning shift between 7 a.m. and 3 p.m. on the morning of June 12, 2012. Mr. London was at the nurses' station on the day in question when he heard Ms. Garrett yell for him. He then saw Client #1 on the floor, assessed him for injuries, range of motion and broken bones. It turned out that Client #1 had a laceration on his forehead and needed minor first-aid.

14. Mr. London testified that he was somewhat familiar with Client #1's care plan. After reviewing the same, he noted that on April 10, 2012, Client #1 had been ordered to have a sensor alarm in place while he was in bed. A helmet for Client #1 was also ordered. He further noted that Client #1 fell down on April 20, 2012. As a result, Client #1's care plan was changed to include that he was to be assisted whenever ambulating to his next destination. Mr. London explained that after the June 12, 2012 incident, Client #1 was ordered to wear hip pads and a body alarm while sitting in a chair. Mr. London explained that body alarms and sensors are put in place so it is known whenever a resident is on the move. He further explained that the least restrictive interventions are sought which explains why the more restrictive body alarm was not ordered back when Client #1 fell on April 20, 2012.

15. After reviewing Attachment 27 to the Final Investigative Report marked as Appellee's Exhibit 1, Mr. London testified that Client #1's fall risk assessment was a 24 and that anything over an 8 is in the high category for risk of falling. He further explained that out of the roughly 85 clients at the GSNF, 80 of them were high risk for falling and that 10-20 of the residents have body alarms.

16. The next to testify was **Mr. Howard J. Klein**, who is the Director of the Division of Employee Management with the Office of Human Resources, with the Appellee, Cabinet for Health and Family Services. Mr. Klein is the Appellee's Appointing Authority and is in charge of putting in place any disciplinary actions after reviewing the circumstances of each case.

17. Appellee's Exhibit 2 was introduced to the record and is a copy of the Appellant's suspension letter dated August 20, 2012. Mr. Klein testified that his reasoning for approving a five-day suspension was based on the Appellant's poor work performance. In essence, the Appellant just did not keep an eye on Client #1, who ended up wandering off and getting himself hurt. In so doing, the Appellant failed to adhere to the care plan and perform her duties.

18. Mr. Klein testified that the five-day suspension was reasonable because in this event the Appellant's work performance was just one notch down from a finding of neglect. Mr. Klein further explained that even though no two cases are exactly the same when there is a finding of neglect, the facility is required to terminate the offending employee.

19. The testimony of Howard J. Klein marked the end of the Appellee's case in chief.

20. The next to testify was the Appellant, **Vickie Larabee**, who has worked as a restorative Nurse Aide at the GSNF for approximately fourteen years. She was working the first shift between 7 a.m. and 3 p.m. on June 12, 2012. Ms. Larabee acknowledged that she was required her to review a patient's care plan each morning and to adhere to the clients' daily care plan throughout the day. A patient's general care plan is found in the patient's medical chart.

21. Ms. Larabee testified she was familiar with Client #1's general care plan and knew he was unsteady on his feet and had a tendency to wander off. Client #1 had been in the facility for several years and had been known to get up and wander off, but this had never happened to the Appellant before.

22. Ms. Larabee explained that Nurse Aides do not dress the residents before breakfast and that this is done by the preceding work shift. However, she acknowledged she was responsible for making certain the patients were properly dressed. On the morning of June 12, 2012, she could not recall if Client #1 had on his skid-proof socks.

23. Ms. Larabee explained that on the morning of June 12, 2012, she was on one side of the restorative dining room feeding a client and a coworker was on the other side doing the same. She testified that she was approximately four feet away from Client #1 who was sitting to her side. She had just glanced over to check on Client #1 and he was just sitting there so she turned her attention back to the client she was helping to feed. She explained that Client #1 got past her because her attention was on the client she was helping to feed.

24. On cross-examination, the Appellant was referred to Attachment 13 to Appellee's Exhibit 1 which was the Appellant's daily care plan. The Appellant admitted she failed to follow this. However, she stated there was no way she could see everything that goes on and if she had seen Client #1 get up she would have helped him.

25. Appellee's Exhibit 3 was introduced into the record and is a copy of the verbal reprimand the Appellant received on February 10, 2012. This reprimand was issued when another client fell while under the Appellant's care. Ms. Larabee testified that Attachment 2 to Appellee's Exhibit 1 is a copy of her statement and demonstrates the layout of the restorative dining room on the morning of June 12, 2012. Finally, she admitted that Client #1 does not walk very fast.

26. The Appellant explained that in her opinion a five-day suspension was excessive because she did not see Client #1 get up. Had she actually seen Client #1 get up and failed to help him, then being penalized would have been expected. However, since performing her job caused her attention to be focused on another client, she did not see Client #1 get out of his chair and should therefore not be held responsible. She also noted that the employees in the hallways should have seen him as well and been required to help him. As she explained, it is hard to see everything that is going on, especially when feeding another resident. In the end, the Appellant accepted responsibility for failing to see Client #1 get up and wander off, but was of the opinion that a five-day suspension was too harsh a penalty.

27. This matter is governed by KRS 18A.095(1) which states:

> A classified employee with status shall not be dismissed, demoted, suspended, or otherwise penalized except for cause.

28. The Hearing Officer has considered the entire administrative record, including the testimony and statements therein.

FINDINGS OF FACT

1. The Appellant, Vickie Larabee, was suspended from duty and pay for a period of five working days from her position as a Nurse Aide State Registered I, with the Department for Behavioral Health, Developmental and Intellectual Disabilities, Glasgow State Nursing Facility (GSNF) for poor work performance. [See Appellee's Exhibit 2.]

2. The Appellant, a classified employee with status, timely filed her appeal with the Personnel Board on September 14, 2012, appealing from her five-day suspension from duty and pay.

3. On June 12, 2012, the Appellant and a coworker, Heather Hagan, were in the restorative dining room at the GSNF assisting clients with their breakfast. Client #1 was also eating his breakfast in the restorative dining room at the time and was under the care and supervision of both Ms. Hagan and the Appellant.

4. The evidence plainly indicates that on June 12, 2012, while under the care and supervision of the Appellant and Ms. Hagan, Client #1 was allowed to wander off into a nearby hallway and ended up falling. As a result of said fall, Client #1 sustained a minor laceration to his forehead and was taken to the hospital as a precautionary measure. Neither the Appellant nor Ms. Hagan noticed that Client #1 had gotten up and wandered off.

5. The Appellant was well aware of Client #1's general and daily care plan and was aware he was unsteady on his feet, had a high risk of falling, and required assistance when ambulating to his next destination.

6. As a result of her failure to properly monitor Client #1 and adhere to his care plan on the morning of June 12, 2012 as set forth above, the Appellant received a five-day suspension from duty and pay as more specifically set out in the suspension letter dated August 20, 2012, and marked as Appellee's Exhibit 2.

CONCLUSION OF LAW

The Appellee has demonstrated by a preponderance of the evidence that the disciplinary action taken against the Appellant, the same being a five-day suspension from duty and pay, was neither excessive nor erroneous and was appropriate under the circumstances.

RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **VICKIE LARABEE VS. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2012-209)** be **DISMISSED.**

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

Any document filed with the Personnel Board shall be served on the opposing party.

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer Geoffrey B. Greenawalt** this 23rd day of July, 2013.

KENTUCKY PERSONNEL BOARD

MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. Michael Board
Vickie Larabee